DO NOT RESUSCITATE ORDERS
AND
WITHDRAWAL OF LIFE-SUSTAINING TREATMENT

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I. Introduction.

As medical technology progressed to the point where a patient's vital signs could be sustained almost indefinitely, society began to question the value of these advancements. If the patient were permanently comatose, unable to interact with his environment, unable to communicate with others, unable to feel and appreciate the soft touch of a loved one's hand, and unable to function at even a basic cognitive level, what purpose was served in keeping him alive? These questions, capturing the apparent conflict between scientific advances and the essence of what it means to be living, were brought into sharp focus when, in 1975, the media began to focus on the case of Karen Ann Quinlan, a 22-year-old, New Jersey woman.

Several weeks after being rushed to the hospital, perhaps following an episode of drug use, Karen Ann Quinlan was described by her physicians as respirator dependent and in a chronic persistent vegetative state with no real hope of return to a cognitive condition. After several months of soul-searching, discussions with physicians, and advice from Roman Catholic clergy, Joseph Quinlan, Karen's father asked her physicians to discontinue the respirator. They refused -–perhaps because they thought doing so would violate the standards of medical practice, perhaps because they feared criminal sanctions. Mr. Quinlan then asked the New Jersey Superior Court to appoint him as Karen's guardian and give him permission to disconnect the respirator. The New Jersey Superior Court denied his petition,[3] but the State's Supreme Court reversed,[4] holding

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[3]*Matter of Quinlan*, 348 A.2d 801 (N.J. Super. Ct. Ch. Div. 1975).
[4]*Matter of Quinlan,* 355 A.2d 647 (N.J. 1976).

that Karen Quinlan's constitutionally based privacy right outweighed the State's interest in preserving life and, since she was incompetent, her father was a proper individual to exercise that right for her. The court also held that the respirator could be withdrawn and that neither the hospital nor Karen Quinlan's father nor her physicians would be subject to any criminal or civil liability.

Following *Quinlan*,[5] numerous cases stressed patient autonomy in decision-making, holding that patients have a right to refuse medical care or treatment,[6] although under certain circumstances that right must be balanced against the state's interests.[7] And, they grounded the right to refuse medical treatment in one of two legal theories: (1) a common law right of autonomy, i.e., a right to be free of intrusion[8] or invasion of bodily integrity[9] or a right of privacy;[10] and (2) a constitutional right, either of privacy[11] or liberty.[12] Moreover every state enacted either a living will statute[13] or a durable

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[5]Id.

[6]A competent adult has a right to make his or her own medical decisions, see, e.g., *Satz v. Perlmutter*, 362 So. 2d 160 (Fla. Dst. Ct. App. 1978); a competent adult does not lose this right upon incompetency; see, e.g., *Brophy v. New England Sinai Hospital*, 398 Mass. 417 (1986); an adult who was never competent has this right, see, e.g., *In the Matter of Sue Ann Lawrance*, 579 N.E.2d 32 (Ind. 1991); and a parent may exercise this right for a minor child, see, e.g., *Rosebush v. Oakland County Prosecutor*, 491 N.W.2d 633 (Mich. Ct. App. 1992).

[7]These state interests include: protection of life, prevention of suicide, protection of innocent third parties, and protection of the ethical integrity of health care providers. *Fosmire v. Nicoleau*, 551 N.E.2d 77 (N.Y. 1990).

[8]*Bouvia v. Superior Court*, 195 Cal. Rptr. 484 (Ct. App. 1983; *In re Torres*, 357, N.W.2d 332 (Minn. 1984); and *In re Conroy*, 486 A.2d 1209 (N.J. 1985).

[9]*Rasmussen v. Fleming*, 741 P.2d 674 (Ariz. 1987); and *In re Doe*, 583 N.E.2d 1263 (Mass. 1992).

[10]*Bouvia v. Superior Court*, 225 Cal.Rptr.297 (Ct. App. 1986); and *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

[11]*Satz v. Perlmutter*, 362 So.2d 160(Fla.Dist. Ct. App. 1978); *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977); *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

[12]Cruzan v. Director, Missouri Dept. of Health, 110 S.Ct. 2841 (1990).

[13]Ala. Code §§ 22-8A-1 to –10; Alaska Stat. §§ 18.12.010-.100; Ariz. Rev. Stat. Ann. §§ 36-3201 to –3262; Ark Code Ann. §§ 20-17-201 to –218; Cal. Health & Safety Code §§ 7185-7194.5; Colo. Rev. Stat. §§ 15-15-101 to –113; Conn. Gen. Stat. Ann. §§ 19a-570 to –580c; Del. Code Ann. tit 16, §§ 2501-1509; Fla. Stat. Ann. §§ 765.101-.401; Ga. Code Ann. §§ 31-32-1 to –12; Haw. Rev. Stat. §§ 327D-1 to –27; Idaho Code §§ 39-4501 to –4509; Ill. Ann. Stat. ch 755, §§ 35/1-10; Ind. Code Ann. §§ 16-36-4-1 to –21; Iowa Code Ann. §§ 144A.1-.12; Kan. Stat. Ann. §§ 65-28,101 to –28,109; Ky. Rev. Stat. Ann. §§ 311.621-.643; La. Rev. Stat. Ann. §§ 40:1299.58.1-.10; Me. Rev. Stat. Ann. tit. 18-A, §§ 5-701 to -714; Md. Code Ann., Health-Gen. §§ 5-601 to –618; Minn. Stat. Ann. §§ 145B.01-.17; Miss. Code Ann. §§ 41-41-101 to 121; Mo.

power of attorney statute that provides for medical decision-making,[14] and many enacted both.[15] Reliance on *do not resuscitate*

Ann. Stat. §§ 459.010-.055; Mont. Code Ann. §§ 50-9-101 to –111. –201 to –206; Neb. Rev. Stat. §§ 20-401 to –416; Nev. Rev. Stat. Ann. §§ 449.535-.690; N.H. Rev. Stat. Ann. §§ 137-H:1-:15; N.J. Stat. Ann. §§ 26:2H-53 to –78; N.M. Stat. Ann. §§ 24-7-1 to –11; N.C. Gen. Stat. §§ 90-320 to –323; N.D. Cent. Code §§ 23-06.4-01 to –14; Ohio Rev. Code Ann. §§ 2133.01-.15; Okla. Stat. Ann. tit. 63, §§ 3101.1-.16; Or. Rev. Stat. §§ 127.505-.660, .995; Pa. Cons. Stat. Ann. tit. 20, §§ 5401-5416; R.I. Gen. Laws §§ 23-4.11.1 to –14; S.C. Code Ann. §§ 44-77-10 to –160; S.D. Codified Laws Ann. §§ 34-12D-1 to –22; Tenn. Code Ann. §§ 32-11-101 to –112; Tex. Health & Safety Code Ann. §§ 672.001-.021; Utah Code Ann. §§ 75-2-1101 to –1119; Vt. Stat. Ann. Tit. 18, §§ 5251-5165 and Vt. Stat. Ann. Tit. 13, § 1801; Va. Code Ann. §§ 54.1-2981 to –2993; Wash. Rev. Code Ann. §§ 70.122.010-.920; W.Va. Code §§ 16-30-1 to –13; Wis. Stat. Ann. §§ 154.01 -.15; Wyo. Stat. §§ 35-22-101 to –109; and D.C. Code Ann. §§ 6-2421 to –2430;

[14]Alaska Stat. §§ 13.26.332-.356; Ariz. Rev. Stat. Ann. §§36-3221 to –3224 and Ariz. Rev. Stat. Ann. § 14-5501; Ark Code Ann. §§ 20-17-202; Cal. Civ. Code §§ 2430-2445, 2500-2510; Colo. Rev. Stat. §§ 15-14-501 to –509 and Col. Rev. Stat. §§ 15.18.5-101 to -103; Conn. Gen. Stat. Ann. §§ 19a-570 to –580c and Conn. Gen. Stat. Ann. §§ 1-42 to -56; Del. Code Ann. tit 16, §§ 2502(b); Fla. Stat. Ann. §§ 765.101-.401 and Fla. Stat. Ann. § 709.8; Ga. Code Ann. §§ 31-36-1 to –13; Haw. Rev. Stat. §§ 551D-1 to 7; Idaho Code §§ 39-4502 to –4509; Ill. Ann. Stat. ch 755, §§ 45/4-1 to -12; Ind. Code Ann. §§ 16-36-1-7; Iowa Code Ann. §§ 144B.1-.12 and Iowa Code Ann. § 633.705; Kan. Stat. Ann. §§ 58-625 to -632; Ky. Rev. Stat. Ann. §§ 311.621-.641; La. Rev. Stat. Ann. §§ 40:1299.58.3 and La. Civ. Code Ann. Art. 2997(A)(7); Me. Rev. Stat. Ann. tit. 18-A, §§ 5-701 to –714 and Me. Rev. Stat. Ann. tit. 18-A §§ 5-501 to -506; Md. Code Ann., Health-Gen. §§ 5-601 to –618 and Md. Code Ann., Est. & Trusts §§ 13-601 to -602; Mass. Gen. Laws Ann. ch. 201D, §§ 1-17; Mich. Comp. Laws § 700.496; Minn. Stat. Ann. §§ 145C.01-.15 and Minn. Stat. Ann. §§ 145B.01-.17; Miss. Code Ann. §§ 41-41-151 to -183; Mo. Ann. Stat. §§ 404.800-.870; Mont. Code Ann. §§ 50-9-101 to –111. –201 to –206 and Mont. Code Ann. §§ 72-5-501 to -502; Neb. Rev. Stat. §§ 30-3401 to –3432; Nev. Rev. Stat. Ann. §§ 449.800-.860 and Nev. Rev. Stat. Ann. §§ 449.535-.690; N.H. Rev. Stat. Ann. §§ 137-J:1-:16; N.J. Stat. Ann. §§ 26:2H-53 to –78 and N.J. Stat. Ann. §§ 46:2B-8; N.M. Stat. Ann. §§ 45-5-501 to -502; N.Y. Pub. Health Law §§ 2980-2994; N.C. Gen. Stat. §§ 32A-15 to -26; N.D. Cent. Code §§ 23-06.5-01 to –18; Ohio Rev. Code Ann. §§ 1337.11-.17; Okla. Stat. Ann. tit. 63, §§ 3101.1-.16; Or. Rev. Stat. §§ 127.005-.737; Pa. Cons. Stat. Ann. tit. 20, §§ 5401-5416 and Pa. Cons. Stat. Ann. tit. 20 §§ 5601-5607; R.I. Gen. Laws §§ 23-4.10.1 to –12; S.C. Code Ann. §§ 62-5-501 to –504 and S.C. Code Ann. § 44-77-50; S.D. Codified Laws Ann. §§ 59-7-2.1 to 2.8 and S.D. Codified Laws Ann. §§ 34-12C-1 to –8; Tenn. Code Ann. §§ 34-6-201 to –215; Tex. Civ. Prac. & Rem. Code Ann. §§ 135.001-.018; Utah Code Ann. §§ 75-2-1101 to –1118; Vt. Stat. Ann. tit. 14, §§ 3451-3467; Va. Code Ann. §§ 54.1-2981 to –2993; Wash. Rev. Code Ann. §§ 11.94.010-.040; W.Va. Code §§ 16-30A-1 to –20; Wis. Stat. Ann. §§ 155.01-.80; Wyo. Stat. §§ 3-5-201 to 213 and Wyo. Stat. § 35-22-102(d); and D.C. Code Ann. §§ 21-2201 to –2213.

[15]Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia,

orders has also become much more common, as has reliance on a patient's or a surrogate's request to withhold or withdraw life-sustaining treatment.

II. Do Not Resuscitate (DNR) Orders in Army MTFs.

A. Background.

As the civilian community grew more comfortable with writing and honoring do not resuscitate (DNR) orders and with withdrawing life support from terminally ill patients, military health care beneficiaries and providers began to ask what the Army's policy was.

In 1978, the Army Health Services Command queried The Army Surgeon General about the applicability of the Texas Natural Death Act,[16] one of the first living will laws. The Surgeon General replied that because of problems created by varying types of jurisdiction and by physician licensure the Act was not to be relied upon in military medical treatment facilities (MTFs) in Texas.[17]

In 1983, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavior Research recommended that institutions develop policies to implement DNR orders in appropriate cases.[18] Two years later, in 1985, The Surgeon General did promulgate a uniform policy permitting, and governing the use of, DNR orders in Army hospitals.[19] Army policy still did not specifically allow withdrawal of life support.[20]

Washington, West Virginia, Wisconsin, and Wyoming, as well as the District of Columbia.

[16]Texas Health and Safety Code Annotated §§ 672.001-.021.

[17]Letter, HQDA, DASG-PSA (13 Dec 77) 1st End., 23 May 1978; Subject: Texas Natural Death Act, reprinted in President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment: Ethical, Medical, and Legal Issues in Treatment Decisions* 520-522 (1983) (hereafter *Deciding to Forego Life-Sustaining Treatment*).

[18]*Deciding to Forego Life-Sustaining Treatment,* 248-255.

[19]Army Reg. 40-3, Medical Services: Medical, Dental, and Veterinary Care, Chap. 19 (15 February 1985) (hereafter AR 40-3).

[20]AR 40-3, para 19-lb.

B. Ch 19 (DNR Orders) of AR 40-3.

Resuscitation efforts will be made for a patient who suffers cardiac or respiratory arrest in an Army hospital *unless* there is a written DNR order in the chart.[21] Therefore, in the absence of a written DNR order, resuscitation efforts will be made. *Slow codes* and *notify MOD*[22] *before coding*[23] practices are implicitly prohibited.

The regulation states that a DNR order is appropriate when patient "will not benefit from resuscitation"[24] and the patient or next-of-kin or legal guardian agrees to the order. *Appropriate* patients "include those who are irreversibly, terminally ill or those in a persistent chronic vegetative state."[25] However, DNR orders are not limited to these patients.

A long line of court decisions recognizes that all competent adults, and the surrogate decision-makers[26] of non-competent patients, have a right to refuse medical treatment.[27] Moreover, this conclusion is not contrary to the regulation which states, "A competent patient has the legal and moral right to refuse medical treatment at any time, even if it is lifesaving."[28] Thus, DNR orders may not be limited to irreversibly, terminally ill patients or those in a persistent vegetative state, and, in

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[21]AR 40-3, para 19-3a. *Resuscitation* refers to any means used to restore ventilatory and or circulatory function until spontaneously resumed or until artificial means are established or until the patient is pronounced dead. A DNR order does not imply the withholding or withdrawal of any other therapy. Comfort care shall still be given. (emphasis added)

[22]*MOD* stands for *Medical Officer of the Day* and often means the physician who first responds to all calls at night.

[23]Such codes are informal agreements among health care providers and family members to delay initiation of CPR. Oftentimes, the patient dies before resuscitation efforts commence.

[24]AR 40-3, para 19-3b.

[25]Id.

[26]Most jurisdictions and ethicists use the term *surrogate decision-maker* to refer to the person authorized to make health care decision on behalf of an incompetent patient. Generally, these surrogates must exercise *substituted judgment*, i.e., must base their decisions on what the patient would have wanted. If the desires of the patient are unknown or unclear, or if the patient was never competent (a child or mentally handicapped adult), the surrogate must act *in the best interest* of the patient. When there is doubt that the surrogate is exercising substituted judgment or acting in the best interest of the patient, the hospital ethics consultant or committee, and perhaps a JAG officer, should be contacted. Should there be a possibility of imminent harm, an attorney from the Legal Office should be consulted immediately.

[27]See Section 1. Introduction, *supra*.

[28]AR 40-3, para 19-3f.

appropriate cases, they may be authorized by an attorney-in-fact pursuant to a durable power of attorney for medical care.[29] Health care providers who have ethical or religious objections to a patient's, or surrogate's, request for a DNR order should promptly should seek consultation with the hospital ethicist or ethics committee and/or transfer the patient's care to another provider.[30]

Discussion of resuscitative efforts should, in appropriate circumstances, be a part of the process of informed decision-making, and it is certainly not wrong for that dialogue to be opened by one of the patient's physicians. Such a discussion might include a description of the potential benefit of resuscitation, the possible ways it can be attempted, the possible harm or resultant injury, and quality-of-life matters. The patient should also be assured that he may rescind a DNR order orally, or in writing, at any time, and he should be given the opportunity to discuss the decision with an ethicist, members of the ethics committee, and/or members of the clergy.---If a patient who requests a DNR order, he will *in no instance be asked to sign a release.*[31] Rescission should be documented in the chart as soon as possible and the health care providing team should be notified.

"Only credentialed physicians who are members of the medical staff may write a DNR order. This does not include physicians in a graduate medical education status,"[32] i.e., residents and interns can not write DNR orders. The order should be documented on the order sheet, dated, and signed.[33] Progress notes should explain the medical rationale for the order, and include a statement regarding the patient's competency. The notes should also indicate, by name and position, who participated in the discussion with the patient or surrogate, e.g., health care providers, clergy, ethicist, members of the ethics committee, and/or family members.

When a competent patient requests, or makes a decision to authorize, a DNR order, he should be asked if family members may be informed of the DNR order.[34] If the patient does not want

[29]See note 12, *supra*.
[30]See also, AR 40-3, para 19-6c.

[31]AR 40-3, para 19-4.
[32]AR 40-3, para 19-3d.
[33]AR 40-3, para 19-4.
[34]AR 40-3, para 19-6d.

family members informed, his wishes shall be honored and this will be documented in the chart by a disinterested physician or nurse.[35] If the patient agrees that family members may be informed, they will not be allowed to override the decision.[36]

The DNR order should be reviewed routinely on rounds and whenever there is a significant improvement in the patient's condition. Because surgical teams routinely perform resuscitation, the appropriateness of a DNR order should be one of the matters discussed by the surgeon, anesthesiologist, and the patient, or surrogate, before surgery. This discussion and the conclusion reached should be documented in the progress notes.

All staff members who interact with patients should be aware that a patient may rescind a DNR order, orally or in writing, at any time. If the individual is authorized to write in a patient's chart, the rescission should be documented immediately and the health care team notified of the rescission. If the individual is not authorized to write in the chart, the head nurse would be a logical person to notify unless local policy specifies that another individual be notified.

III. Withdrawal of Life-Sustaining Treatment in Army MTFs.

A. Background.

The ink was hardly dry on the new Army regulatory provision[37] when, complaining of shortness of breath and chest pain, Mrs. Martha Tune, the 71-year-old widow of an Army officer, entered Walter Reed Army Medical Center on February 21, 1985.[38] Her physicians placed her on mechanical ventilation to treat her respiratory problems. Tests revealed cardiac compression and adenocarcinoma in the lungs. Mrs. Tune developed adult respiratory distress syndrome and became respirator - dependent.[39] The respirator only prolonged the inevitable. She asked the physicians to remove the respirator and allow her to die naturally, and her family supported her decision. However,

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[35]Id.
[36]Id.
[37]AR 40-3, Chapter 19.
[38]*Tune v. Walter Reed Army Medical Center*, 602 F. Supp.1452, 1453 (D.D.C. 1985).
[39]Id.

in accordance with Army policy,[40] her physicians refused. On February 27, 1985, in the District Court for the District of Columbia, Mrs. Tune's son sought an order requiring Walter Reed to remove her from the respirator.[41] The court appointed a guardian *ad litem* who determined that Mrs. Tune suffered from a terminal illness but that she was competent to make her own medical decisions. Judge Jackson ordered Walter Reed to remove the respirator and stated, "It is now a well-established rule of general law, as binding upon the government as it is upon the medical profession at large, that it is the patient, not the physician, who ultimately decides if treatment -- any treatment -- is to be given at all."[42]

In August, 1985, soon after the decision in *Tune*, The Surgeon General published a uniform policy allowing withdrawal of life-sustaining treatment under specified circumstances

C. Letter on Withdrawing/Withholding Life-Sustaining Treatment.

Deciding to Forego Life-Sustaining Treatment,[43] and *Tune v. Walter Reed Army Medical Center*[44] influenced the Army's policy on the withdrawal or withholding of life-sustaining treatment, a policy embodied in an August 30, 1985, letter from the Department of the Army, Office of the Adjutant General (Letter, DASG-PSQ dtd 30 Aug 85), (hereinafter, Letter).[45] It asserts that "(t)he Army Medical Department is committed to the principle of supporting and sustaining life *when it is reasonable to do so*."[46] (emphasis added) It allows competent patients in a terminal condition[47] or a incompetent patients' persistent or chronic vegetative state[48] to decline life-sustaining treatment.[49] It

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[40]Id. Mrs. Tune's doctors stated that had they known the full extent of her illness, they would not have ordered the respirator in the first place.
[41]Id.
[42]Id. at 1455.
[43]See note 16, *supra*.
[44]602 F. Supp. 1452 (D.D.C. 1985). See discussion at Section 1, paragraph 1, supra.
[45]A copy of the letter is appended.
[46]Letter, para 3a, emphasis added.
[47]*Terminal condition* is defined as an "incurable condition resulting from injury or disease in which imminent death is predictable with reasonable medical certainty." (Letter,DASG-PSQ, dtd 30 Aug 85, para 2b)
[48]*Persistent or chronic vegetative state* is defined as a "chronic state of diminished consciousness resulting from severe generalized brain injury in which there is no reasonable possibility of improvement to a cognitive state." (Letter, para 2c)
[49]Id. at paras 3 and 4a.

also allows the next-of- kin or legal guardian to decide whether treatment should be withdrawn if the patient is incompetent.[50]

As with DNR orders, Army policy must also recognize the law of the jurisdiction in which the military medical treatment facility is located. Competent patients and surrogate decision-makers may well have the right to refuse or withdraw life-sustaining treatment even if the patient's condition is not terminal or if the patient is not in a persistent or chronic vegetative state.[51]

Life-sustaining treatment "means any medical procedures or intervention which serves only to artificially prolong dying ... Intravenous therapies and lavage feeding are medical interventions. Medical interventions necessary to alleviate pain are not considered life-sustaining treatment."[52] This definition clarifies the fact orders to withdraw or withhold life-sustaining treatment should not affect pain management, i.e., palliative care or comfort care. It should be carefully explained to patients that they not be *abandoned* if withdraw or withhold orders are entered.

The definition of *life-sustaining treatment* also includes artificial food and hydration,[53] but some patients, or surrogates, may wish to have food and hydration continued even though they wish to forego other interventions. Care should be taken to discuss *all* types of life sustaining treatment and to accurately capture the wishes of the decision-maker, whether patient or surrogate, in the written order.

As with DNR orders, discussion of life-sustaining treatment should be part of the overall informed decision-making process.

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[50]Id. at para 4b.

[51]See Section 2, para c. See also *Bouvia v. Superior Court*, 179 CalApp.3d 1127, 255 Cal.Rptr. 297 (1986), where the right to have life support disconnected was not limited to comatose or terminally ill patients. Such cases should be dealt with individually, with advice from an attorney from the JAG Office.

[52]Letter, DASG-PSQ dtd 30 Aug 85, para 2a.

[53]Several courts have allowed the withdrawal or withholding of nutrition and hydration in appropriate cases. See e.g., *In re Gardner*, 534 A.2d 947 (Me. 1987); *In re Grant*, 747 P.2d 445 (Wash. 1987); *In re Peter*, 529 A.2d 419 (N.J. 1987); *Brophy v. New England Sinai Hosp. Inc.*, 398 Mass. 417, 497 N.E.2d 626 (Mass. 1986); *Matter of Conroy*, 98 N.J. 321; 486 A.2d 1209 (N.J. 1985); *Delio v. Westchester County Medical Center*, 129 A.D.2d 1, 516 N.Y.S.2d 677 (N.Y.App.Div. 1987); *Corbett v. D'Alessandra*, 487 So.2d 368 (Fla.App. 1986); *Bouvia v. Superior Court*, 179 Cal.App.3d 1127, 225 Cal.Rptr. 297 (Cal.Ct.App. 1986).

Health care providers with ethical objections to the withdrawal or withholding of life-sustaining treatment may consult with an ethicist, if one is on staff, or with members of the hospital ethics committee and/or may transfer care of appropriate patients to other providers.

The attending physician shall enter the written order in the chart,[54] and shall sign and date the order. Nurses should not accept verbal orders. As with DNR orders, progress notes should (a) explain the medical rationale for the order,[55] (b) include a statement regarding the patient's competency and the basis for a finding of incompetency, if any,[56](c) indicate who participated in the discussion with the patient or surrogate, and (d) state whether the patient wishes family members to know about the order.[57] The patient may rescind an order to withhold or withdraw life-sustaining treatment, orally or in writing, at any time. Rescission should be documented in the chart and the health care providing team should be notified.

III. Conclusion.

A decision to enter a DNR or a withhold/withdraw order is one that truly may be termed a matter of life or death. It concerns the most profound, personal and familial interests and may well raise the most fundamental questions of personhood and humanity. Physicians, nurses, ethicists, lawyers, clergy, family, and friends, as well as the patient and, in some situations, the patient's surrogate may be involved. The interests of these parties may converge but they are not identical; dialogue is essential to understanding and to the resolution of conflict.

[54]Letter, para 5a.
[55]Id.
[56]Id.
[57]Letter, para 4a.

Letter, Subject: WITHDRAWAL OF LIFE-SUSTAINING TREATMENT

Letter, HQDA, DASG-PSQ, 30 Aug 85, SUBJECT: Withdrawal of Life-Sustaining Treatment (see footnote 15, *supra*) is attached. This letter signed by The Adjutant General is still current policy and should be followed in conjunction with AR 40-3, Chapter 19 (as applicable) until changed by the next AR 40-3 UPDATE or other relevant publication.

DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, DC 20310-2100

DASG-PSQ 30 Aug 1985

SUBJECT: Withdrawal of Life-Sustaining Treatment

Commander
US Army Health Services Command
Fort Sam Houston, TX 78234-6000

1. Reference AR 40-3, chapter 19.

2. This letter provides policy and procedures (end) for the implementation of withdrawal of life-sustaining treatment within the Army Medical Department
(AMEDD).

3. The attached procedures will be implemented effective immediately by all medical treatment facilities within your command per instructions contained in the procedures.

4. These procedures will be published in AR 40-3 at its next UPDATE printing.

Questions concerning the procedures should be directed to HQDA(DASG-PSQ), 5111 Leesburg Pike, Falls Church, VA 22041-3258.

BY THE ORDER OF THE SECRETARY OF THE ARMY:

Original Signed
Adjutant General

Encl
CF:
Commanders
US Army Health Services Command (HSCL-Q)
US Army Medical Research and Development Command (SGRD-OP)

Enclosure: WITHDRAWAL OF LIFE-SUSTAINING TREATMENT

1. Purpose. This letter sets policy and defines procedures for withdrawal of life-sustaining treatment. It implements recommendations of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical Behavioral Research.

2. Explanation of terms.

a. Life-sustaining or life-prolonging in treatment means any medical procedure or intervention which serves only to artificially prolong dying of a qualified patient (defined below). Intravenous therapies and lavage feeding are interventions. Medical interventions necessary to alleviate pain are not considered life-sustaining treatment.

b. Terminal condition means an incurable condition resulting from injury or disease in which imminent death is predictable with reasonable medical certainty

c. Persistent or chronic vegetative state is a chronic state of diminished consciousness resulting from severe generalized brain injury in which there is reasonable possibility of improvement to a cognitive state.

d. Attending physician means a member of the medical staff with MD or DO degree who has primary responsibility for the treatment and care of the patient. Interns and residents are excluded.

e. A competent patient is an adult (18 years of age or over or emancipated minor as determined by State law) who has the ability to communicate and understand information and the ability to reason and deliberate about the choices involved. Some exceptions have been created for “mature” minors in recognition that sometimes children have adequate capacity to make decisions. However, a minor below 14 years old will remain incompetent. Emancipated minor includes 17-year old AD service members.

f. An incompetent patient is a minor (17 years of age and under and not emancipated) (see also e above) or someone who does not have the ability to reason and deliberate about the choices involved in his or her medical care. Lack of capacity

should be verifiable by clinical assessment of the patient’s mental and emotional status.

g. A qualified patient is a patient diagnosed and certified in writing by at least two physicians as afflicted with a terminal condition or as being in a persistent or chronic vegetative state. One of the physicians will be the patient's attending physician. Interns and residents are excluded.

h. Treatment *having* no beneficial prospect means that its continued use will not improve the prognosis for recovery.

i. An Ethics Panel is an ad hoc advisory committee composed of individuals from a variety of disciplines. Membership should be balanced, with no single individual profession, or discipline dominating the committee. Committee membership may be drawn from administration, medicine, nursing, pastoral care, social work or the community. A representative of the local staff judge advocate will, however, be a member. This committee is convened by the Commander or Deputy Commander of Clinical Services (DCCS) in those situations where there is doubt concerning the propriety of withdrawing life-sustaining treatment or where there is disagreement among the treating physicians, members of the family, or between the treating physician and members of the family.

3. Policy.

a. The Army Medical Department is committed to the principle of supporting and sustaining life when it is reasonable to do so. Life-supporting techniques and the application of medical technology may not cure a patient’s disease or disability or reverse a patient's course. Some patients who suffer from terminal illness and are incurable may reach a point where continued or additional treatment is not only unwanted by the patient but medically unsound. In such cases, medical treatment does not prevent death but merely defers the moment of its occurrence. The attending physician must decide whether continual efforts constitute a reasonable attempt at prolonging life or whether the patient's illness has reached. Such a point that further intensive, or extensive, care is in fact merely postponing the moment of death which is otherwise imminent.

b. Life-sustaining treatment of an incompetent terminally ill patient or one who is in a persistent or chronic vegetative

state may be terminated with the consent of NOK or legal guardian and attending physician.

c. When a physician's assessment conflicts with that of an incompetence patient's guardian or next of kin (NOK), further discussion, consultation, and review by the Ethics Panel, should be sought.

d. If there is disagreement concerning the diagnosis or prognosis or both, life-sustaining treatment will be continued until reasonable agreement is reached.

4. Patient's Desires.

a. Where the patient is competent and alert, and understands the implications of his or her diagnosis and prognosis, the decision to withhold or withdraw life-sustaining treatment should be reached by the patient after discussion with the attending physician. The patient should be encouraged to discuss the subject with family members before making this decision. However, a competent, alert patient might elect not to inform family members of his or her decision or seek their concurrence. Such decision will be documented in the medical record. A competent patient who has requested termination of life-sustaining treatment may change his or her mind at any time. Medical personnel will proceed in accordance with the patient's wishes.

b. When a patient is incompetent, a decision based on the patient's best interest should be reached after consultation with the patient's guardian or NOK and the attending physician. Factors to be considered in determining what actions are in the patient's best interest include the--

(1) Relief of suffering,

(2) Quality as well as extent of life sustained, and

(3) “Substituted judgment doctrine”: What the patient would have wanted if competent. If an incompetent patient has *no* family or legal guardian and the treating staff concludes that withdrawal of life-sustaining treatment is proper, consultation should be undertaken with the DCCS and the Ethics Panel.

5. Documentation of an order for withdrawal of life-sustaining treatment.

a. An order to terminate life-sustaining treatment will be entered by the attending physician in the Doctors Orders, timed, dated and signed legibly. Documentation in the Progress Notes will include--

(1) A description of the patient’s medical condition corroborating the prognosis, including reference to any consultations relevant to the decision to terminate.

(2) *A* summary of discussions with the patient, NOK or guardian concerning the medical prognosis and the withdrawal of life-sustaining treatment.

(3) The competency status of the patient and the basis for a finding of incompetency.

(4) The authority upon which the final decision is based (e.g., competent patient's informed consent, Ethics Panel, court, etc.).

b. The attending physician will promptly inform the DCCS and personnel who are responsible for the patient's care, particularly the nursing staff, about the decision to withdraw life-sustaining treatment.

6. Education. The education of health care professionals will be a joint educational endeavor including at least physicians. nurses, and the chaplain. The training will include training in ethical decision making, patient confidentiality, effects upon family members, and training for assisting patients and families in making decisions for or against withdrawal of life sustaining treatment.